TEXAS DEPARTMENT OF HEALTH
EMERGENCY INDUCED ABORTION CERTIFICATION FORM

Name of physician performing the procedure: _____

Texas License Number: _____

Information on facility where procedure performed:

Name _____

Address _____

Telephone Number _____

Date of Procedure: _____

"The patient whom this certification concerns is an unemancipated minor. Based on my good faith clinical judgment, I hereby affirm that the following medical condition(s) necessitated the immediate abortion of my patient's pregnancy without prior parental notice otherwise required by Family Code §33.002 to avert her death or to avoid a serious risk of substantial and irreversible impairment of a major bodily function. I understand this certification is confidential and may not contain personal or identifying information about my patient, including her name, address, or social security number. I have included a copy of this certification in my patient's medical record as required by law."

List the medical indications supporting the physician's judgment:

_____

_____

_____

_____

_____ _____

Physician's Signature Date

_____

Physician's Printed Name

Please mail the completed form to the following:

Statistical Services Division
PO Box 4124
Austin, TX 78765-4124

Any person other than the intended recipient who receives this document in error is hereby notified that any disclosure, copying, distribution, use or taking of any action in reliance on the contents of this document is strictly prohibited. Please notify the Texas Department of Health at 512-458-7509 immediately to arrange for return of this document to the department.

TDH-EIA-5-2000